

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CMS 1500 - (formerly L&I Health Ins Claim form)  
DEPARTMENT OF LABOR AND INDUSTRIES  
CLAIMS SECTION  
PO BOX 44269  
OLYMPIA WA 98504-4269

PICA										PICA																																																																																																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																													
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																																																																													
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																																																																																													
ZIP CODE					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (INCLUDE AREA CODE) ( )																																																																																																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																													
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																													
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																																																																																																																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																							
SIGNED _____										DATE _____										SIGNED _____																																																																																																													
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																													
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																																																																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										23. PRIOR AUTHORIZATION NUMBER																																																																																																																							
1. _____										3. _____																																																																																																																							
2. _____										4. _____																																																																																																																							
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY										B Place of Service										C Type of Service										D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCCPS MODIFIER										E DIAGNOSIS CODE										F \$ CHARGES										G DAYS OR UNITS										H EPSDT Family Plan										I EMG										J COB										K RESERVED FOR LOCAL USE																													
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ _____										29. AMOUNT PAID \$ _____										30. BALANCE DUE \$ _____																																																																															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #:																																																																																																													
SIGNED _____										DATE _____										PIN# _____										GRP# _____																																																																																																			